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Chairman Hatch, Ranking Member Wyden and other members of Finance Committee, thank you for this opportunity to share work of the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis and the RUPRI Health Panel, as well as other published research and reports. I will focus on three areas of particular relevance, rural experience with Medicare's accountable care organizations, or ACOs; payment policies driving changes in delivery systems; and use of telehealth. I will conclude with general observations about future directions in rural health policy

## **Background**

While some things have changed in the 30 years I have been conducting rural health research and policy analysis, the underlying rural dynamics remain much the same. But we have some new tools, both in health care delivery and through public policy, to help us continue our quest to establish and sustain a high performance rural health system.

I have come to appreciate the nexus of what we in the research community contribute to your efforts, and the concerns/needs of our colleagues delivering healthcare services. As President of the National Rural Health Association in 1996 I represented the interests of rural providers in policy discussions. One of my funded projects in the late 1990s was to work with rural providers in Nebraska and Iowa to develop the template for a provider-sponsored Medicare+Choice plan. Much of my research involves site visits to rural health care organizations to understand the implications of Medicare and other policies on what they are able to do in their communities.

My personal engagement and that of the RUPRI Center, the RUPRI Health Panel, the Rural Telehealth Research Center (based in Iowa), and collaborations with others covers a host specific topics of interest to this Committee. They include Medicare Advantage, rural ACOs, access to rural pharmacy services, rural implications of changes in health care delivery and organization, delivery system reform initiatives in Medicare and Medicaid payment, the evolution of the marketplace in health insurance coverage, and the role of telehealth.

## **Medicare ACOs (Shared Savings Plans and demonstrations)**

Rural presence in ACO activities has grown dramatically, as of the end of 2016 in 22 percent of rural counties at least 30 percent of Medicare beneficiaries were attributed to ACOs. Also by the end of 2016 there were nearly 40 percent of rural (non-metropolitan) counties with at least 3 ACOs with attributed beneficiaries, up from 17 percent in 2014.<sup>i</sup> As of the end of 2017 at least one Medicare ACO was operating in 60 percent of rural counties.<sup>ii</sup> Maps showing the

spread of rural ACOs based on attributed lives for each year 2014-2016, and a map showing presence of ACOs based on where there are participating providers, are in an attachment.

Factors accounting for the increased rural participation include:

- demonstration programs making advanced payments available to invest in information systems and other start-up costs,
- national firms supporting multiple ACOs (aggregators that centralize functions such as data analytics),
- rural health care organizations already engaged in care management and perhaps even performance based contracting,
- network development among rural health care organizations (HCOs), and
- spread of urban-based systems into rural regions.

What have we learned from the early adopters of the ACO model in rural areas? We know that experience matters, both prior experience in network development and care management, and experience gained as a result of functioning as an ACO. Approaches to developing ACOs vary considerably, from a single regional system like the Billings Clinic and affiliates in Montana, to rural networks like the Illinois Critical Access Hospital Network, to affiliations of geographically disperse HCOs under a national organization such as CaravanHealth, to spread of urban-based ACOs. We also know that there is not a “typical ACO model,” that in rural areas in particular we are seeing different strategies for building aggregations of HCOs to reach the critical mass in attributed beneficiaries necessary to generate savings from affecting the care-seeking behavior of historically high users of expensive services.

Tables 1-3 display characteristics of 525 Medicare Shared Savings Plans (MSSP) and Next-Gen ACOs, based on the RUPRI data about where there are providers participating in those ACOs. We classify ACOs based on the counties in which they have providers, so “100 percent nonmetro” means that all counties of the ACO with participating providers are designated nonmetropolitan; “70% - 99%” is again based on the percent of all counties in which the ACO has participating providers. As we should expect, a majority of ACOs are in metropolitan or mostly metropolitan areas. However, as of 2017 there were 53 ACOs operating exclusively or mostly in nonmetropolitan counties, and nearly all of the AIM ACOs, as intended, serve nonmetropolitan counties. Table 3 demonstrates the strong preference of rural-based ACOs for the Track 1 model, but nearly 14 percent of those in the categories of mostly nonmetropolitan and mixed are participating in Track 3 or Next Generation ACOs. Table 4 uses these same categories of ACOs on a nonmetropolitan – metropolitan scale to display other characteristics of interest. Notably, rural ACOs are more likely to be non-profit and less likely to be independent hospitals. We have much to learn about the interaction of ACO development and

sustainability of rural health infrastructure, an ongoing project of the RUPRI Center for Rural Health Policy Analysis.

**Table 1: Medicare ACOs by Metropolitan/Nonmetropolitan County Presence, as of January 2017**

Metro/Nonmetro	Description	Count	Percentage
Nonmetro	100% nonmetro counties	8	1.5%
Mostly nonmetro	70%-99% nonmetro counties	45	8.7%
Mixed	30%-69% nonmetro counties	144	27.7%
Mostly metro	1%-29% nonmetro counties	112	21.5%
Metro	0% nonmetro counties	211	40.6%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations.

**Table 2: Medicare ACO Participation in AIM, by Metropolitan/Nonmetropolitan County Presence, as of January 2017**

Metro/Nonmetro	Description	AIM Participaton	
		Count	Percentage
Nonmetro	100% nonmetro counties	6	75.0%
Mostly nonmetro	70%-99% nonmetro counties	16	35.6%
Mixed	30%-69% nonmetro counties	16	11.1%
Mostly metro	1%-29% nonmetro counties	2	1.8%
Metro	0% nonmetro counties	5	2.4%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations; and CMS “ACO Investment Model” data (<https://innovation.cms.gov/initiatives/ACO-Investment-Model/>, accessed 4/14/2018).

**Table 3: Medicare ACO Model Participation, by Metropolitan/Nonmetropolitan County Presence, as of January 2017**

Metro/Nonmetro	Description	Track 1		Track 2		Track 3		Next Gen	
		Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct
Nonmetro	100% nonmetro counties	8	100%	0	0%	0	0%	0	0%
Mostly nonmetro	70%-99% nonmetro counties	42	93.3%	0	0%	1	2.2%	2	4.4%
Mixed	30%-69% nonmetro counties	124	86.1%	0	0%	9	6.3%	11	7.6%
Mostly metro	1%-29% nonmetro counties	95	84.8%	2	1.8%	5	4.5%	10	8.9%
Metro	0% nonmetro counties	172	81.5%	3	1.4%	14	6.6%	22	10.4%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations.

**Table 4: Medicare ACO Characteristics**

Characteristic	Non-Metro		Mostly non-Metro		Mixed		Mostly Metro		Metropol.		Total	
	Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct
ACO "For Profit" Status												
For-profit	0	--	0	0%	18	45.0%	15	32.6%	25	54.3%	58	41.1%
Not-for-profit	0	--	9	100%	22	55.0%	31	67.4%	21	45.7%	83	58.9%
ACO Taxonomy type												
Expanded Phys. Group	0	--	5	26.3%	22	25.3%	23	26.1%	30	20.8%	80	23.7%
Full-Spectrum	0	--	1	5.3%	17	19.5%	15	17.1%	16	11.1%	49	14.5%
Hospital Alliance	0	--	2	10.5%	11	12.6%	13	14.8%	13	9.0%	39	11.5%
Independent Hospital	0	--	4	21.1%	8	9.2%	10	11.4%	11	7.6%	33	9.8%
Indep. Physician Group	0	--	4	21.1%	14	16.1%	15	17.1%	48	33.3%	81	24.0%
Physician Grp Alliance	0	--	3	15.8%	15	17.2%	12	13.6%	26	18.1%	56	16.6%
Sponsoring Entity Type												
Hospital system	1	16.7%	14	36.8%	52	44.1%	52	53.1%	59	34.3%	178	41.2%
Physician group	1	16.7%	8	21.1%	38	32.2%	37	37.8%	85	49.4%	169	39.1%
Other	4	66.7%	16	42.1%	28	23.7%	9	9.2%	28	16.3%	85	19.7%
Provider Type												
Hospital system	2	33.3%	7	18.9%	27	22.1%	28	28.3%	31	17.6%	95	21.6%
Physician group	3	50.0%	15	40.5%	50	41.0%	32	32.3%	83	47.2%	183	41.6%
Both	1	16.7%	15	40.5%	45	36.9%	39	39.4%	62	35.2%	162	36.8%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations; and Levitt Partners Torch Insight Database (<https://torchinsight.com/>, 2018). .

**Metropolitan/Non-Metro categories:**

- Nonmetro: 100% nonmetro counties
- Mostly nonmetro: 70%-99% nonmetro counties
- Mixed: 30%-69% nonmetro counties
- Mostly metro: 1%-29% nonmetro counties
- Metro: 0% nonmetro counties

**ACO Taxonomy Type** (Leavitt Partners' classification) - A categorization of ACOs based on organizational structure, ownership, and patient care focus:

- Expanded Physician Group: ACOs who directly provide outpatient services, but will contract with other providers to offer hospital or subspecialty services.
- Full Spectrum Integrated: ACOs who provide all aspects of healthcare to their patients. ACOs in this classification are often dominated by a large integrated delivery network.
- Hospital Alliance: ACOs who have multiple owners with at least one of those owners directly providing inpatient services.
- Independent Hospital: ACOs who have a single owner and directly provides inpatient services, but do not provide subspecialty care. Outpatient services could also be directly provided by this type of ACO if the owner is an integrated health system.
- Independent Physician Group: ACOs who have a single physician group owner and do not contract with other providers to offer additional services.
- Physician Group Alliance: ACOs who may have multiple physician group owners — often including multi-specialty groups — but do not contract with other providers to offer additional services.

**Provider Type** - The type of provider organizations that are participating in an ACO. Options include: "Hospital System", "Physician Group" and "Both". For the purpose of this field "Hospital System" refers to any organization that owns and operates a hospital. The "Both" option is appropriate when there is a single organization, such as an integrated delivery network, that includes both a hospital system and a physician group as well as when there are separate hospital system and physician group organizations participating in the ACO.

There have been two recent “pushes” of the ACO model in rural places. First, the ACO Investment Model (AIM) has provided start-up capital to qualifying organizations, and the criteria are weighted in favor of small (by beneficiary count) rural ACOs. Second, regional and national organizations are providing administrative support, and in some instances training in care management, to geographically disperse provider organizations. Several Management Service Organizations serve at least 15 ACOs, including ones in nonmetropolitan areas:

- Aledade (16 total ACOs, 10 nonmetro/mostly nonmetro/mixed)
- CaravanHealth (22 total ACOs, 21 nonmetro/mostly nonmetro/mixed)
- Collaborative Health Systems (19 total ACOs, 6 nonmetro/mostly nonmetro/mixed)
- Imperium Health (15 total ACOs, 7 nonmetro/mostly nonmetro/mixed).

While there is debate regarding the aggregate impact of ACOs on Medicare spending, our research and that of others find improvements in the quality measures used in the program. Rural ACOs, for example perform well (better than urban counterparts) on care management/patient safety and preventive health domains. Expenditure savings vary; a 2017 OIG report found net reduction in spending across all ACOs, but concentrated in less than half of them. Eight of the 11 rural ACOs in the Advanced Payment Model, an early demonstration prior to the current AIM demonstration, generated savings. Analysis of 2016 final reports showed that 56 percent of MSSP ACOs saved Medicare expenditures, with 31 percent receiving share savings bonuses.<sup>iii</sup>

We are at a critical point in time in learning from the experiences of early entrants into the Medicare ACO program. Some important questions should be addressed. Is the policy goal solely to continuously show lower expenditures versus a target influenced by the ACO’s own previous success and the regional market? Are there benefits to this payment model related to changes in delivery models, including greater likelihood of achieving the triple aim of improved patient experience, better health, and lower costs? Should policy continuously accommodate different cost savings expectations, given variability in circumstances across all participating ACOs? Should variations of advanced payment (perhaps as grants) continue to be available? Finally, what is the next iteration of payment reform that builds from the experiences of ACOs – perhaps global budgeting?

### **Payment policies and delivery system reform**

The ACO program is generating a great deal of attention, but it is but only one approach to payment reform designed to motivate changes in the health care delivery system (delivery system reform or DSR). We should expect more payment reform initiatives going forward, including implement of physician payment reform. As we do so the RUPRI Panel encourages attention to five rural specific considerations:

1. Organize rural health systems to create integrated care.
2. Build rural system capacity to support integrated care.
3. Facilitate rural participation in value-based payments.
4. Align Medicare payment and performance assessment policies with Medicaid and commercial payers.
5. Develop rural-appropriate payment systems.

In discussing each of those considerations, the Panel provides specific suggestions in our *Policy Paper*, which can be downloaded from the Panel's web site: [http://www.rupri.org/wp-content/uploads/FORHP-comments-km-DSR-PANEL-DOCUMENT PRD Review 112315.clean-4 sn-3.pdf](http://www.rupri.org/wp-content/uploads/FORHP-comments-km-DSR-PANEL-DOCUMENT_PRD_Review_112315.clean-4_sn-3.pdf).

In general, payment policies should be sensitive to the rural practice environment, including population density, distances to providers, infrastructure investment including information technology and data analytics capabilities, and opportunities to develop models that actually take advantage of smaller scale and integrating all local services with those provided at some distance. One example of that sensitivity is to be aware of differences in readiness to change. For example, our analysis of 2015 data from physician compare shows that among categories of urban, rural, and "mixed" physician practice locations, rural practices were least likely to report quality measures (58.5 percent) and use electronic records (17.7 percent). These data indicate a need for a modified timeline to implement payment reform, and/or a rationale to provide additional technical assistance and access to capital.

## **Telehealth**

Appropriate use of telehealth, the third are of focus in my testimony, could facilitate taking full advantage of the strengths of the rural model, focused on direct patient engagement from a primary care base. Studies completed by the RUPRI Center ([www.ruprihealth.org](http://www.ruprihealth.org)) and underway by the National Center for Rural Telehealth Research ([www.ruraltelehealth.org](http://www.ruraltelehealth.org)), show that telehealth can be a tool that reinforces and augments care provided by primary care providers (PCPs) in rural settings. Access to specialist services included in the continuum of care initiated by PCPs is enhanced when the specialist is brought to the rural site through telehealth. Further, virtual office visits and home monitoring provide the specialist with information needed to manage chronic conditions.

In our research focused on use of telehealth in hospital facilities we found that tele-emergency care enhanced local access by having board-certified emergency doctors available on call. This was instrumental in recruiting and retaining primary care physicians who knew they had the support of those board certified physicians who see many cases of what in a rural

setting are infrequent occurrences. We also found reported improvements in quality of care, greater ability to focus on patient needs, and improved community support of the local hospital. Use of telehealth services is expected to increase, especially given provisions in the Chronic Care Act section of the Bipartisan Balanced Budget Act. As that happens there are ongoing policy considerations. First, fee-for-service payment policies need to be in place allowing payment for services delivered through telehealth. As payment evolves away from fee-for-service telehealth should be supported as a means to the achieving the triple aim. Second, support is needed for ongoing research indicating when telehealth services add value to health care delivery.

### **Concluding observations**

I now offer general observations based on the past several years of RUPRI Health Panel work in policy analysis and using our framework of a high performance rural health delivery system. We are in a time of transformation in health care, both in what is possible in delivery and how we pay for services. In this time of health care transformation, we should provide support to rural providers who because of the scale of their organizations cannot adapt as rapidly as the system may change. Rural HCOs may need access to investment capital they are unable to generate on their own as they participate in new, better ways of organizing services. Many rural HCOs want to participate in delivery system reform and new payment methodologies, but we should test ideas and programs specific to rural circumstances, as is underway in Pennsylvania. Payment policies and alternative sources of financial support should recognize the importance of access to services in places wherein patient revenue will not be sufficient to cover all costs.

I offer these observations about how approach changes to policies affecting rural health delivery:

- We should think in terms of total cost of care, not the prices of individual services or single encounters.
- New approaches to delivering services and payment policies should be coordinated across payers.
- Individual and population health are affected by circumstances and policies beyond the immediate purview of health policies; that interaction should be considered in a rural context.

Finally, I offer other resources as the Committee considers policy improvements serving rural America. I realize that much attention focuses on the closure of rural hospitals and the struggles those remaining open incur to meet financial needs. Discussions about future action



include thinking through alternative models for rural communities. Abrupt closure of the local hospital should not be an option because there will residents who lose access to essential services as a result. The RUPRI Health Panel has completed work to summarize and compare alternative models for rural communities, accessible from our web site: <http://www.rupri.org/wp-content/uploads/Alternatives-for-Developing-the-High-Performance-Rural-Health-System-FIN....pdf>. But the issues facing rural communities are much more encompassing than the focus on hospitals, and communities fortunate to have a viable, robust hospital delivery system still confront questions about how to transform to a value-based system. In addition to our work on Medicare payment reform, the Health Panel published a document describing challenges and opportunities for rural health systems in Medicare payment and delivery system reform: <http://www.rupri.org/wp-content/uploads/RUPRI-Health-Panel-Medicaid-Payment-and-Delivery-System-Reform-June-2016.pdf>. Finally, the RUPRI Health Panel is committed to helping providers and policy makers learn of options that advance us toward a high performance rural health system. We established a framework for defining that end objective in documents released in 2011, with a follow up document in 2014 suggesting a specific strategy: <http://www.rupri.org/wp-content/uploads/2014/11/Advancing-the-Transition-Health-Panel-Brief.pdf>.

More recently, the Health Panel completed a comprehensive assessment of progress of health system transformation, including impacts on rural health delivery and outcomes for rural populations. We included an assessment of remaining gaps and how policies across seven topical areas could address them. The areas are Medicare, Medicaid and CHIP, Insurance Coverage and Affordability, Quality, Healthcare Finance and System Transformation, Workforce, and Population Health. The document (Taking Stock: Policy Opportunities for Advancing Rural Health) can be accessed as a single download, or by the chapters just enumerated: <http://www.rupri.org/areas-of-work/health-policy/#paneldochealth>.<sup>iv</sup> The RUPRI Center for Rural Health Policy Analysis, as referenced earlier in this testimony, publishes research briefs and papers, as well as scholarly journal articles, on a number of topics. Those topics include Medicare Advantage, health insurance markets, rural pharmacies, rural ACOs, and physician payment. The Center's web site is [www.ruprihealth.org](http://www.ruprihealth.org).<sup>v</sup>

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<sup>i</sup> A Clinton MacKinney, F Ullrich, and K Mueller (2018) "Medicare Accountable Care Organization Growth in Rural America, 2014-2016." *RUPRI Center Data Report* Brief No. 2018-1. March. [www.public-health.uiowa.edu/rupri/](http://www.public-health.uiowa.edu/rupri/).

<sup>ii</sup> Document in development; based on RUPRI Center for Rural Health Policy Analysis data set that plots location of health care providers included in ACOs

<sup>iii</sup> Saunders, R, Mulestein D, and McClellan M (2017) Medicare Accountable Care Organization Results for 2016: Seeing Improvement, Transformation Takes Time. *Health Affairs Blog* November 21. 10.1377/hblog20171120.211043.

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